The Brandon Trust

Windermere Road Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 28 and 29 April 2015 and was unannounced. Windermere Road Nursing Home is registered to provide accommodation, nursing care and personal care for up to 12 adults with a learning disability, physical disability and/or complex health issues. Care is provided in three bungalows that are all linked to a shared kitchen, office and medicines room.

11 people were living at the home when we visited and most people needed help with all aspects of nutrition, personal care and moving about. People also needed staff to help them if they became confused or anxious. Staff support was provided at the home at all times and people required the support of one or more staff when away from the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had decisions made on their behalf that were not fully documented to make sure their changing needs and circumstances were addressed. Some people did not receive their medicines as prescribed as a result of administration errors. You can see what action we told the provider to take at the back of the full version of this report.

Whilst most staff supported people in a thoughtful and caring manner, we observed some instances when staff did not communicate effectively or did not fully consider the situation from the perspective of the person being supported. Most permanent staff knew people well and understood their needs. Some bank or agency staff lacked this detailed knowledge to help them support people in line with their needs and preferences. The registered manager was working to recruit a full staff team to reduce the reliance on bank and agency staff.

Some people had complex physical needs and healthcare professionals said staff followed their guidance but some felt this was not always sustained. Concerns were raised about staff not always following eating and drinking plans and postural guidance precisely.

Staff supported people to take part in activities they knew matched the person's individual preferences and interests. Most of the time people were encouraged to make choices and to do things for themselves as far as possible. In order to achieve this, a balance was struck between keeping people safe and supporting them to take risks and develop their independence.

Staff felt well supported and had the training they needed to provide support to each person. Staff met with their line manager to discuss their development needs and action was taken when concerns were raised. Learning took place following any incidents to prevent them happening again. Staff understood what they needed to do if they had concerns about the way a person was being treated. Staff were prepared to challenge and address poor care to keep people safe and happy.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. People received the medicines they needed from trained staff but a number of errors had occurred which resulted in people not receiving their medicines as prescribed.

Sufficient staff were on duty but bank and agency staff were not as able to understand people's needs as the permanent staff. The premises were clean and work was planned to improve the environment.

The risks people faced had been assessed and the need to keep people safe was balanced with the need to respect their choices. They were protected from preventable harm as learning and action took place following any incidents and staff had a good understanding of safeguarding requirements.

Is the service effective?

Requires improvement

The service was not always effective. People had decisions made on their behalf that were not fully documented to make sure their changing needs and circumstances were addressed.

People were supported to stay well and have a healthy diet. Some healthcare professionals raised concerns that people were put at risk as eating and drinking plans were not followed precisely and people were not always supported to maintain a safe posture.

The training staff needed to support people had been assessed and the registered manager was developing plans to address the gaps identified. Staff met with their line manager to receive feedback on their practice and discuss developmental needs.

Is the service caring?

Requires improvement

The service was not always caring. Most staff communicated with people and supported them in a thoughtful and caring way. Some staff, however, missed opportunities to involve people in decisions or to communicate effectively with them.

Relatives and visiting therapists spoke positively about the care provided. Staff were prepared to challenge and address poor care. Managers took action to support staff to improve or took disciplinary action if needed.

Staff understood the importance of dignity and confidentiality. Most staff knew people well and treated them as individuals.

Summary of findings

Is the service responsive?

Requires improvement 

The service was mostly responsive. Most staff knew people well and people's support plans generally reflected their needs and preferences. Each person was treated as an individual. People were supported to take part in a variety of activities in the home and the community.

Complaints had been dealt with appropriately in the past and relatives said they would be able to complain if they needed to. Staff monitored people's behaviour to identify if they were unhappy.

Is the service well-led?

Good 

The service was generally well-led. The quality of the service was regularly checked and areas for improvement were addressed.

People and their family members were asked for feedback and their comments were acted on. Feedback from other agencies was also acted on to improve the service provided.

The registered manager was supported by the provider to manage the service effectively. There was an open culture. Staff understood their responsibilities and felt able to share concerns with the registered manager.

Windermere Road Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 and 29 April 2015 and was unannounced. An adult social care inspector carried out this inspection.

Before the visit we reviewed previous inspection reports, notifications and enquiries we had received. Services tell us about important events relating to the service they provide using a notification. We spoke with a local authority commissioner and read a recent quality review by the local authority.

During our visit we spoke with the registered manager, two nurses and five care staff. We spent time observing the care and support provided by staff and spoke with one relative. We spoke with two therapists who regularly attended the home and three healthcare professionals. We looked at three support plans, staff training records and a selection of quality monitoring documents.

After our visit we spoke with two relatives and three further healthcare professionals.

Requires improvement

Is the service safe?

Our findings

Most people received their medicines when they needed them from trained staff who had access to the information they needed to safely administer them. However, in March 2015 five medicines errors occurred and in April 2015 seven errors occurred. Some of these were administration errors which resulted in people not receiving their medicines as prescribed. This put them at risk of harm. We observed the nurse being disturbed a number of times whilst administering medicines despite wearing a tabard to remind others they should not be disturbed. We also observed a nurse asking another member of the nursing team to administer medicines they had already dispensed. The nurse offered an explanation but secondary dispensing is always considered poor practice as it increases the risk of administration errors. The provider's medicines policy did not allow secondary dispensing.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the registered manager shared an action plan with us detailing how the number of medicines errors would be reduced. This focussed on reducing the number of distractions the nurse administering the medicines was exposed to. When a medicines error occurred, the resulting action was determined using an assessment tool which took factors such as previous errors into account. For example, if the same member of staff made repeated errors, the resulting action was more significant than after the first occurrence. We saw evidence to show action was taken following errors.

People's medicines were stored safely to prevent errors. Medicines were dated on opening to make sure staff disposed of expired medicines at the right time. Medicines that needed additional security were managed in line with the law. Each person had protocols in place for the medicines they had been prescribed that could be taken as needed. This ensured staff knew when and how they should be offered to people. A medicines communication book had been introduced to help nursing staff share information about changes to people's medicines. A medicines audit took place each month and the storage and recording of medicines were reviewed. Where necessary, action was taken to address issues identified such as ensuring all medicines were signed for on administration.

There were enough staff on duty to meet people's needs. The number of staff needed for each shift was calculated by taking into account the level of care commissioned by the local authority and knowledge of the activities to take place that day. Staff confirmed that the required number of staff were on duty for each shift. During April 2015, 15% of the nursing hours were provided by bank staff and 11% by agency staff. In the same time period, 38% of the care worker hours were covered by agency staff. Healthcare professionals told us bank and agency staff did not understand people's needs as well as permanent staff. We observed that whilst bank and agency staff kept people safe, they were not as able to understand what people were trying to communicate and were not as creative in engaging people as permanent staff. Recruitment was ongoing to reduce the reliance on non-permanent staff.

Incidents were recorded and reviewed and this resulted in changes to people's risk assessments and support plans. All incident reports were reviewed by the registered manager and staff at head office to identify any patterns and to make sure the necessary actions had been completed. The risk of people suffering preventable harm was reduced because learning and action took place following any incidents. This reduced the likelihood of similar incidents occurring in the future. Some actions, such as informing the local authority safeguarding team of relevant incidents, were not clearly recorded although we were told they had taken place. This made it more difficult to confirm the appropriate action had been taken.

Each bedroom and bathroom had a ceiling hoist to allow staff to move people safely. Each hoist in use had a sticker to show when it had last been serviced. These were in date but the staff relied on the servicing company to tell them when a service was due and did not monitor this themselves. This increased the risk equipment might not be serviced as often as it should be. Staff used slings to hoist people and these were checked daily for signs of wear. New slings had recently been purchased and instructions for using them were on the wall in each room. Each person had enough slings to allow them to be washed and dried regularly.

Requires improvement

Is the service safe?

People lived in a home that was clean but showed some signs of wear and tear. For example, the carpets were stained and damaged in areas. The registered manager told us the carpets were due to be replaced with a more suitable surface by the maintenance company. Staff had a system for requesting building maintenance and they said requests were actioned in a timely fashion. A food hygiene inspection had recently been completed and the home had been awarded two out of five stars (improvement necessary). Improvements had been made since the last inspection but further actions were required to address shortcomings, such as the cleaning of food probes.

As a result of a fire risk assessment, evacuation plans and individual risk assessments had been produced for each person. Fire drills had been completed along with alarm and emergency lighting checks. Information about how people responded to the fire drills had not yet been included in each person's risk assessment. Other safety checks, such as electrical device testing and water temperature checks were completed by the housing provider or staff. A weekly health and safety check was completed in each bungalow and an external company had completed an additional audit. Actions from the checks, such as improving the door thresholds, were being addressed.

The risks people faced were being managed by staff. The way these risks should be managed had been recorded using risk assessments which showed how the risk had been weighed up and reduced. For example, one person was at risk of falling out of bed but as they disliked closed spaces, a low bed and crash mats had been used in favour of bed rails. Staff described how they balanced risks with people's right to make choices. The assessments had been updated after significant events such as a hospital admission. Staff took positive risks to give people opportunities. For example, a ball pool had been fitted and an overhead hoist had been provided to help people safely access the ball pool. The risks could not be totally eliminated but people were still given the opportunity to enjoy the experience.

People were cared for by suitable staff because safe recruitment procedures were in place and managed by the provider. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to establish whether the applicant has any convictions that may prevent them working with vulnerable people. Where necessary, a risk assessment was completed prior to employing staff. Any gaps in an applicant's employment record were followed up to ensure a full history was obtained. Where possible, prospective staff were interviewed at the home to ensure they understood the service and to allow current staff to observe how they interacted with people using the service.

People were supported by staff who had access to guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. They had received safeguarding training and safeguarding was discussed at staff meetings and individual supervision meetings. Staff described the correct sequence of actions to follow if they suspected abuse was taking place. They said they would report abuse and were confident the registered manager would act on their concerns. The registered manager explained she operated an open door policy for anyone wanting to share a concern.

Most people would be unable to verbally communicate if they were being abused so staff monitored their behaviour for unexpected changes that needed following up. Staff were aware of the whistleblowing policy and the option to take concerns to appropriate agencies outside the home if they felt they were not being dealt with effectively. Staff told us they had reported concerns and these had been acted on by the registered manager in a timely fashion. This had included contacting external agencies for guidance and protecting people using the service.

Requires improvement

Is the service effective?

Our findings

People's rights under the Mental Capacity Act 2005 (MCA) were not always being met. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. A mental capacity assessment and record of the decisions made was in place for most but not every significant decision that had been taken on behalf of a person without mental capacity to make that decision. For example, an assessment was not in place where two people had bed rails in place. This increased the risk that people's rights under the MCA may not be fully respected. **This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

All but three staff had completed MCA training since joining the company but the missing MCA assessments and best interest decisions indicated staff had not fully understood their responsibilities under the MCA. Care workers had a good understanding of the need to help people make decisions on a day to day basis. They told us they would consult with senior staff if someone needed to make a more significant decision.

People's ability to choose where to live had been assessed and appropriate steps had been taken if they could not make this decision. Staff respected people's legal rights under the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. Applications to deprive people of their liberty had been made to the local authority when needed.

People's health needs were recorded in their health action plan. People also had a hospital passport in place to guide professionals if they needed to be admitted. The person's key worker and nursing staff booked routine health appointments as needed. One relative felt staff had a very good understanding of how unwell their relative was and the importance of close monitoring.

Some healthcare professionals we spoke with told us staff had a good knowledge of the people they supported and made timely and appropriate referrals. They told us staff followed the plans in place to keep people well and acted in a supportive and caring manner. Other healthcare professionals felt some staff lacked a full understanding of people's conditions and the importance of following support plans precisely. Healthcare professionals said staff generally acted on any guidance given but some said this was not always sustained over time. Particular concerns were raised around the use of equipment to help people maintain a safe posture and the way people were supported during mealtimes.

Some people living at Windermere Road Nursing Home received nutrition via percutaneous endoscopic gastrostomy (PEG) tubes into their stomachs. A room in the home was used to store the products prescribed to feed each person and plans were displayed in the room to ensure staff had the information they needed to give each person the correct nutrition. One healthcare professional raised concerns about a bank member of staff not positioning a person at the right angle before feeding via a PEG tube. This put the person at risk of harm. Staff told us they understood the protocols for each person.

Some people received most of their nutrition through a PEG tube but also had the opportunity to eat a little food for pleasure. Staff described how important this was for some people's quality of life. Some people were able to feed themselves at mealtimes. They were provided with the correct crockery and utensils to help them eat independently. Staff followed one person's support plan by putting food on their spoon when they became distracted and stopped eating. One relative said they felt the food had improved as the meals were more balanced and included more meat and vegetables. People appeared to enjoy the food prepared for them.

Two healthcare professionals raised concerns about individuals not being supported in line with their eating and drinking plans. They described people being given food that put them at increased risk of choking or not being supported to sit properly during a mealtime. They said on questioning staff had been unaware of the guidelines or had not understood the importance of following them precisely. The registered manager was aware of these concerns and was using observations to ensure staff acted correctly in the future.

The building had been personalised with pictures that were significant to each person. There were areas where people could spend time together or they could use their bedroom if they wanted to be alone. The building had been designed to meet people's needs. For example, there was enough

Requires improvement

Is the service effective?

space for people to use their wheelchairs and ceiling hoists were provided in each room. Adaptations were being made for one person living with dementia, such as making the support handles in the toilet red. Each of the three bungalows was accessed via a sitting room. This area became very busy with staff popping in and out, particularly during mealtimes. This could be upsetting for people with dementia or autism.

People were supported by staff who had received training specific to their needs. For example, training on supporting people with epilepsy. Autism training had been arranged after a healthcare professional had identified some staff lacked an understanding of this condition. Plans were in place to ensure all staff completed training in dementia as staff now supported a person living with dementia. Staff told us they felt competent and could ask for additional training when they needed it. The local authority had recently identified weaknesses in the training records and gaps in staff training. The registered manager showed us that records had since been updated and work was being done to address the gaps.

Care workers were observed undertaking tasks such as feeding people via a PEG tube by senior staff to make sure they were competent to do so. They also took part in observational supervision meetings during which their general caring skills were observed and commented upon.

Supervision meetings took place and staff were given the opportunity to discuss their training and development needs, concerns and positive progress. They also discussed the needs of the people they worked closely with. There was not always a clear record to show that issues from the previous meeting were robustly followed up.

The qualified nursing staff were supported to maintain their professional registration by completing relevant ongoing training. This had included courses on using syringe drivers and tissue viability. Observations were completed every six months to make sure qualified staff had the necessary skills. This included the use of feeding tubes and using suction equipment.

The registered manager told us new staff were expected to complete all training identified as mandatory by the company within six months of starting. Plans were in place to support new staff to complete the Care Certificate which is the benchmark for good practice for the induction of fundamental skills, knowledge, values and behaviours for new starters in health and adult social care services. When temporary staff worked at the service, head office checked they had the necessary training to support the people using the service. Agency staff we spoke with told us the permanent staff they worked with were helpful and provided guidance and support as needed. They said they had read people's support plans.

Requires improvement

Is the service caring?

Our findings

The majority of staff acted in a caring and professional manner to help make Windermere Road Nursing Home a pleasant place to live. On occasion, however, staff missed opportunities to involve people in decisions or to communicate effectively with them. One relative told us the care was, "very good" and another said, "it is as good as I can expect it to be". Relatives said they felt very involved in their relation's care planning and felt staff had listened to them. A relative said they felt, "very much a part of the team" and another described being involved in the last care planning meeting. Staff knew they could arrange an advocate for people who did not have friends or relatives to support them with choices.

Visiting therapists said they found staff helpful and felt they knew people well. They said they observed staff interacting well with people. One therapist felt some agency and bank staff did not demonstrate the same level of empathy and understanding as the permanent staff. Some healthcare professionals told us staff acted in a caring and respectful manner which ensured people's dignity and privacy were maintained.

Most staff had a good knowledge of the people living at Windermere Road Nursing Home. Staff explained what could upset people, what helped them stay calm and what people were interested in. This matched what was recorded in people's support plans. We saw staff applying this knowledge during our visit. Most staff responded quickly if people showed signs of distress and spent time with the person to find out what the problem was. When they were unsure what might be causing the person distress, staff sought guidance from more experienced staff. However, agency staff had less knowledge about people. They told us they had read people's support plans but were unable to talk in detail about people's needs and preferences.

Most people could not use words to communicate. New staff spent time with more experienced staff learning what different sounds or movements may mean for people. Most staff had a good understanding of people's preferences and were careful to communicate in a thoughtful manner. For example, they knelt down so they were at the same level as people using a wheelchair. One member of staff talked with a person whilst taking their pulse and temperature. They explained what was happening and sought permission before continuing. Other staff seemed less aware of the importance of communicating effectively. For example, speaking with other staff about the person without any attempt to help the person feel involved in the conversation.

Some people were encouraged to make choices, for example about what they drank, when they got up or where they spent time. Staff explained choices to people and then waited for a response. The choices were offered at the appropriate level and ranged from selecting from two objects to discussing plans for the day. However, we also observed staff missing opportunities to involve people in decisions. For example, moving a person without directly explaining what was about to happen or getting their agreement. On a few occasions, staff left people in a position that made it hard for them to see the television or what was going on around them in the room. We observed a person becoming distressed as a result.

Staff encouraged people to be as independent as possible. They gave people the time they needed to complete tasks themselves and did not intervene too soon. During mealtimes people were encouraged to eat as independently as possible. Each person's support plan identified what the person could do independently and where help should be offered. The plans also included any information known about their cultural and religious preferences and their sexuality. One person was supported to attend a place of worship when they were well enough. When they could not go out, staff replicated the setting in the home using music and lighting.

Staff were aware of the need to protect people's dignity, particularly whilst helping them with personal care and during hoisting. Dignity and privacy were mentioned in people's personal care support plans to give staff practical guidance. Dignity and quality of care had been discussed at recent team meetings. Staff held confidential conversations away from other people. When people were asked if they needed the toilet staff spoke quietly so others could not hear. Care records were stored securely to make sure people's personal information was kept confidential. Staff spoke about people and to people in a respectful way.

The risk of people experiencing poor care was reduced as staff and the registered manager were prepared to address problems as they arose, either through staff development or disciplinary action. The way staff supported people was checked during observations to make sure they were

Requires improvement

Is the service caring?

following company policy and people's support plans. Staff received feedback to help them improve the way they worked with people. If necessary, disciplinary action was taken when performance dropped below the expected standards.

One person had been diagnosed with a terminal condition and staff were working with palliative care specialists to develop a plan to care for this person. Staff had completed training about supporting people at the end of their lives and further training was being sought.

Requires improvement

Is the service responsive?

Our findings

One person had recently moved into the home from another home owned by the same provider. As a result, the structure of their support plans matched the plans in use at Windermere Road Nursing Home. Staff were using the support plans from the previous home whilst they got to know the person and then planned to update them. One healthcare professional had observed staff did not have all the necessary knowledge to support one person following a move from another home. They had observed a member of staff not following the person's eating guidelines which put the person at risk of harm.

Each person using the service had a support plan which was personal to them and gave others information they would need to support them in a safe and respectful way. Staff had assessed each person's needs over time using input from people's families and health and social care professionals. One family member said they regularly reviewed their relative's support plan and felt it was an accurate description of the support the person needed. There was a record of who had contributed to the plan and how involved the person concerned had been. The local authority had recently identified some support plans did not reflect current professional guidance. People's support plans had been updated to include this guidance but some important details, such as the positioning of equipment, were still missing or had not been updated. The registered manager told us this would be addressed.

Support plans included information on maintaining people's health, their daily routines, how to support them emotionally and how they communicated. It was clear what the person could do themselves and the support they needed. Information on the person's known preferences and personal history was also included. Where people could become very anxious, there was clear information about how to support them to manage their anxiety.

People were mostly supported by staff who could explain their needs and preferences in detail. Some staff needed guidance from more experienced staff when we asked questions about people's needs and preferences. Staff got to know each person and the support provided was built around their unique needs. Staff monitored how people responded to different situations and used this to build up a picture of their likes and dislikes. When changes occurred and new information came to light, the person's care plan was updated. Changes to people's needs and preferences were shared using a communications book and at meetings between each shift. Each person's needs and progress were also discussed at monthly key worker meetings.

Each person's support plans were reviewed every three months and changes were made as needed. Their general health, finances, activities and mental capacity assessments were also assessed. People met with staff and their families on an annual basis to decide what they wanted to aim to achieve in the coming 12 months. These meetings resulted in a number of goals that staff helped people achieve. Progress was reviewed every three months. One person had been very unwell and this had impacted on their ability to work towards the goals agreed at their last person centred planning meeting. There was no evidence in their three monthly review that the goals had been reviewed and changed since they became unwell. Staff knew the person could not work towards the goals but had not yet looked at alternatives. Another person's review clearly recorded progress they had made against their personal goals and identified what the next steps would be.

A relative told us their relation enjoyed going out on trips and felt they were supported to go out enough. An activity coordinator for Brandon Trust was based at Windermere Road Nursing Home. They had arranged a number of activities such as a skittles team, swimming and a knitting club. They had spent time identifying potential activities and had then worked with people to find which activities suited them. They had also purchased equipment to help staff with activities within the home such as a giant games and floor puzzles. The activities co-ordinator described how staff had become increasingly willing and able to engage people in activities. They were now working on putting together a list of suggested activities known to work well for each person. They also planned to monitor each person's activity level to make sure no one got forgotten.

The service had a complaints procedure and complaints were recorded and addressed in line with this procedure. Relatives told us they would be happy to tell staff if there was a problem and knew it would be acted on. The complaints received in the last 12 months had all been investigated, acted on and followed up. Most people living

Requires improvement

Is the service responsive?

at the home would be unable to make a complaint verbally so staff monitored their behaviour for changes. If someone's behaviour changed, staff tried to find out if they were unhappy and address it.

Good

Is the service well-led?

Our findings

We asked staff about the vision of the service. They all responded with comments along the lines of, "giving people the best possible quality of life". We observed most staff acting in accordance with these values. The registered manager explained this vision was harder to achieve with a high proportion of bank and agency staff and was working towards recruiting a full permanent staff team. She explained that because she only recruited staff that she genuinely felt would follow this vision, recruitment was a slow process.

Staff were committed to listening to people's views and the views of the people important to them in order to improve the service. Most people could not express their views using words so staff gathered feedback by monitoring people's mood and behaviour. People who could communicate verbally had an opportunity to discuss concerns at meetings with their key worker. People's relatives and health and social care professionals were asked for feedback and actions were taken to address any concerns. A summary of the actions taken had been recorded and these included reviewing the activities one person took part in.

Staff felt able to share concerns or suggestions at team meetings or during meetings with their line manager. They described how their ideas had been listened to and acted on where possible. For example, one member of staff had been supported to rearrange a person's room to give them more space and this had involved moving the tracking for the ceiling hoist. Staff were positive about the support they received to do their jobs and said they understood their roles and responsibilities.

The registered manager split her time across two services. She was supported by a deputy manager and qualified nurses. Staff spoke highly of the registered manager, saying she was accessible and listened to their concerns and suggestions. One relative told us the registered manager was very accessible and "shared information at the right time". Another relative said "she gets things done very quickly". The registered manager met with her line manager to monitor her performance and discuss concerns and plans to develop the service every six months. The registered manager attended meetings with other registered managers in the area to share good practice and enhance her learning. She also took part in a special interest group for inclusion.

A new schedule of monthly quality visits based on the Care Quality Commission (CQC) five key questions was being introduced. Prior to this, quality visits were undertaken by managers from other services. Under the new system, the same external manager would complete each visit which would allow them to follow up actions from the previous visit. Prior to each visit, the staff team was asked to discuss the key question to help the registered manager gather relevant evidence. Action plans were produced following each quality check and staff showed us the progress that had been made against these actions. The actions included implementing daily sling checks and updating staff training records. Incidents and accidents were reviewed every six months to check for patterns that needed addressing.

The problems identified in other parts of this report, such as the number of medicines errors, had already been identified by the registered manager. She was taking action to address the issues but as they were primarily related to high levels of agency and bank staff this would take time to fully address.

Important information is shared with the CQC using notifications. The service had submitted notifications to CQC and this helped us to monitor the safety and effectiveness of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person was not acting in accordance with the 2005 Act when people were unable to give consent because they lacked capacity to do so.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not ensured that medicines were managed in a proper and safe manner.**